☐ Flu Shot _____
☐ Screening _____

THE University of Vermont MEDICAL CENTER

Employee Registration Form

This form needs to be completely filled out prior to screening in order to accurately bill your insurance. There will be no cost to you. All information is strictly confidential. Thank you for your time and attention.

Date of Service: _____

Employer: _____

Employer Phone: _____

Are you covered by employer's insurance? Y ☐ N ☐

EMPLOYEE DEMOGRAPHIC INFORMATION			
Last Name:	First Name:	Middle Initial:	Title(Mr. Ms. Mrs. Miss. Jr. Sr.):

Date of Birth:	Sex:	Social Security Number:	Primary Phone Number:
		- -	

Street Address:

City:	State:	Zip:

PRIMARY INSURED INFORMATION (IF DIFFERENT THAN ABOVE)		
Name of Primary Insured:	Insured Date of Birth:	Home Phone:

Address (if different):	Relationship to Insured:

INSURANCE INFORMATION		
Please Indicate Primary Insurance:	Insurance Plan Name:	Employer's Group Number:

Member ID # with Alpha Prefix:

Insurance Effective Date: